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HIPAA Authorization

Version 2.5

For the Use, Creation and/or Release of Protected Health Information for Research

Research Title:	Home Base Asthma Support and Education (HomeBASE)
Lead researcher:	James Krieger, MD, MPH
Institution of lead researcher:	Public Health Seattle-King County/Prevention Division

A. Purpose of this form

The purpose of this form is to give your permission to the research team to obtain, use, and release your protected health information. Your health information will be used to do the research named above.

> *This document is also used for parents to provide permission about the protected health information of their minor children, and for legally-authorized representatives of (such as an appropriate family member) to provide permission about the protected health information of subjects who are not capable themselves of providing permission. In such cases, the terms "you" and "your health information" generally refer to the subject rather than the permission providing permission.*

State and federal privacy laws protect your health information. These laws say that, in most cases, your health care provider can release your identifiable health information to the research team only if you give permission by signing this form.

You do not have to sign this permission form. If you do not, you will not be allowed to join the research study. Your decision to not sign this permission will not affect any other treatment, health care, enrollment in health plans or eligibility for benefits.

B. The protected health information that will be released and used

"Protected health information" means the health information in your medical records. It also includes information that can identify you. For example, it can include your name, address, phone number, birthdate, and medical record number.

By signing this form you are giving permission to this organization(s) to disclose your protected health information for this research:

The specific information that will be released and used for this research is listed below:

- Medical history / treatment for asthma .

C. How your health information will be used

The researcher will use your health information only in the ways that are described in the research consent form that you sign and as described here.

The privacy laws do not always require the receiver of your information to keep your information confidential. Because of this, the research consent form describes who will have access to your

information. It also describes h[illegible] your information will be protected. Yo[illegible] can ask questions about what the research team will do with your information and how they will protect it.

Your health information in the research records may be shared with, used by, or seen by

- People from agencies and organizations who watch the safety, effectiveness, and performance of the research.
- Other researchers, when a review board approves the sharing of the health information

If any of these people or groups review your research record, they may also need to review the same parts of your original health care record that the research team will see.

D. Research information in your health care record

Some limited and basic information about this research will be placed in your health care record. This is so that your health care provider will know that you are in this research study.

The following information from the research will be put into your health care record.
It includes: summaries of the home visit and confirmation of your enrollment into the study.

E. Expiration

This permission for the release of your health information:

This permission is for the health care provided beginning on the date you sign the informed consent form and enroll in the study. This permission: ends on 3/31/2017 when the research ends and any required monitoring of the study is finished.

This permission for the research team to **use** your health information after they have obtained it: ends when the research ends and any required monitoring of the study is finished.

F. Canceling your permission

You may change your mind at any time. To take back your permission, you must send your **written** request to:

Miriam Philby, MA
King County Asthma Program
401 Fifth Avenue, Suite 900
Seattle, WA 98104-1818

If you take back your permission, the research team will still keep, use, and disclose any health information about you that they already have. But they can't obtain more health information about you for this research unless it is required by a federal agency that is monitoring the research.

If you take back your permission, you will need to leave the research study. This means that you would not have any more research treatments or tests. Changing your mind will not affect any other treatment, payment, health care, enrollment in health plans or eligibility for benefits.

G. Permission for information

You will receive a copy of this signed form. Please keep it with your personal records.

Your health record may have specially protected health information. Put your initials on the line(s) below, if you **don't** want the research team to record or use this specific information.

_____ Sexually transmitted disease
_____ AIDS or HIV
_____ Behavioral or mental health services, including psychotherapy notes
_____ Drug or alcohol abuse, diagnosis, or treatment

_____
Printed Name of Research Subject Birthdate

_____
Signature of Research Subject Date of signature

_____
Printed Name of Subject's Representative

_____
Signature of Subject's Representative Date of signature

_____
Description of Representative's authority to act for subject (for example: parent)